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A STUDY TO DETERMINE THE COST ADVANTAGE OF ESTABLISHING AN INTERNAL CHAMPUS PARTNERSHIP WITH CIVILIAN PROVIDERS FOR THE DELIVERY OF MENTAL HEALTH SERVICES IN THE CATCHMENT AREA OF THE NAVAL MEDICAL CLINIC ANNAPOLIS, MD

A Graduate Management Project
Submitted to the Faculty of
Baylor University
In Partial Fulfillment of the
Requirements for the Degree
of
Master of Health Care Administration

By
LT Donna M. Gutierrez, MSC, USN

June 12, 1992

ABSTRACT

The present environment of constrained resources in which military medicine must operate has necessitated the search for alternative health care delivery mechanisms. Efforts are being directed towards improving access to care for eligible beneficiaries and shifting the financial investment away from CHAMPUS. The purpose of this study is to examine an alternative delivery system for mental health services at Naval Medical Clinic, Annapolis, Maryland which has the potential of resulting in a cost savings for the government. Specifically, the study determines whether or not there is a cost advantage in establishing an internal CHAMPUS partnership with a civilian provider for the delivery of mental health care.

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CHAPTER I

INTRODUCTION

Conditions Which Prompted the Study

The mission of the Navy Medical Department is twofold:

1. To meet operational and wartime requirements
2. To deliver health care to eligible beneficiaries during peacetime.

There are currently 2.5 million Navy and Marine Corps beneficiaries who are eligible to receive health care provided by the Navy. These 2.5 million beneficiaries can be separated into categories as follows:

814,000 Active Duty Navy and Marine Corps

745,000 Active Duty Dependents

934,000 Retirees, Dependents of Retirees, and Survivors (Report, 1)

Members of the other branches of service are eligible for care in the Navy system as well.

The peacetime demands for health care and the readiness requirements for wartime are growing at a rate faster than available resources. The ability to treat the beneficiary population in Navy treatment facilities has not been maintained (Report, 7). The result of increasingly insufficient health care resources is the shift of patient workload from Navy direct care to the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). From Fiscal Year 1985 to Fiscal Year 1988, outpatient visits in Navy treatment facilities decreased 21 percent and admissions to Navy facilities decreased 17 percent. For the same time period, CHAMPUS outpatient visits experienced a 78 percent increase. Admissions under CHAMPUS to civilian

facilities increased 42 percent ("In-house", 2).

There are several significant factors which have been instrumental in facilitating the shift of workload from in-house to the CHAMPUS program. The first factor involves a change in the beneficiary population. As a result of the all-volunteer military force, the Navy has experienced a 200 percent increase in the number of retirees and dependents during the past 20 years ("Costs, Access", 21). There has been a 12.8 percent increase in Navy active duty personnel since 1980 and these active duty members are now more likely to have dependents. In addition, retirees and their families are aging and require more intensive and costly health care ("In-house", 2).

Operational medical support requirements have increased significantly in recent years. Deployed operational medical mandays tripled from 1982 to 1987. During fiscal year 1987, 10 percent of man-years available in both surgery and anesthesiology services were used for operational deployments (Report, 5). As a result, fewer resources were available to provide care to eligible beneficiaries in CONUS. Preparations for deployments also result in further loss of productivity, as do efforts to rebuild practices upon return (Report, 5).

Another factor influencing the trend of shifting workload to CHAMPUS is the advent of new programs which have been implemented without additional resources. One such new program impacting upon resources for other direct care services is the Navy Pride and Professionalism Program (Report, 5). Under this program, Navy members must complete Physical Readiness Tests on a semi-annual basis. A current physical exam and completion of a Risk Factor Screen questionnaire are required. Any member who indicates the presence of a risk factor or who exceeds body fat

percentage limits must be medically evaluated before testing.

The intensification of the Navy's quality assurance (QA) program has also had an impact upon resources available for direct patient care. Allegations concerning the poor quality of health care in the Navy system in the early 1980's necessitated the strengthening of QA efforts. In order to ensure compliance with national standards of care, every medical and dental facility is continuously monitored for integrity and competence. A peer review system is used by the QA program wherein health care providers review the care rendered by their colleagues and document their findings. This increasing emphasis on QA has been successful in improving the quality of health care delivered. Malpractice claims filed against the government for problems associated with care in Navy treatment facilities decreased 33 percent during the time from fiscal year 1985 to fiscal year 1987. Actions against individual physicians have declined by 50 percent (Report, 6). The administrative burden imposed by the QA program has resulted in a decrease in workload capability in Navy facilities, as no supplemental resources have been provided to support this program (Report, 6).

The shift from Navy direct care to CHAMPUS has been further advanced by the increasing costs for health care delivery (All Hands, 2). The Navy faces financial pressures similar to those faced by the private sector health care industry. Medical cost inflation has been increasing at a rate considerably greater than increases in the Consumer Price Index (CPI). As cited in the Report of the Medical Blue Ribbon Panel, the National Center for Health Statistics reported that, for the period from 1960 to 1985, the average daily cost for a hospital room increased at a rate 1,200 percent faster than the costs for other goods and

services (6-7). This has resulted in restriction of in-house workload capability ("In-house", 2). The rate of inflation is projected to continue increasing through 1990 (Report, 7). A comparison of medical cost inflation and the CPI is depicted in Appendix A.

Many problems have occurred as a direct result of the shift in workload away from Navy treatment facilities to CHAMPUS (Report, 9). Three particular areas of concern are the increased costs for the Navy, the increased costs for the beneficiaries, and the decrease in morale and retention.

The costs borne by the government for the provision of patient care under the CHAMPUS program are generally higher than the costs for providing equivalent care in a military treatment facility (MTF). The overall costs to the government have risen as CHAMPUS costs have grown. The Navy's costs for CHAMPUS actually increased 46 percent during the period of time from 1985 to 1987 (Report, 9).

CHAMPUS is a cost share program with annual deductible fees paid by beneficiaries. For outpatient care costs above the deductible, dependents of active duty members pay 20 percent of CHAMPUS allowable charges and retirees and their dependents pay 25 percent. Dependents of active duty members pay $8 per day or $25 (whichever is greater) for inpatient care under CHAMPUS, while retirees and dependents of retirees must pay 25 percent of the total costs for inpatient care. These expenses can be quite high, especially for retirees with fixed incomes and for junior active duty members with growing families to support (Report, 9). As of 1 October, 1987, a catastrophic cap was placed on the cost shares for CHAMPUS beneficiaries for each fiscal year. The cap for each fiscal year is $1,000 for active duty families and

$10,000 for all other categories of beneficiaries. This cap, however, applies only to allowable charges. Any charges in excess of the allowable amount and charges for treatment not covered by CHAMPUS are excluded from the catastrophic cap (CHAMPUS Handbook, 63).

According to VADM James A. Zimble, Surgeon General of the Navy, family members of Navy active duty personnel prefer to receive health care in Navy facilities ("In-house", 2). With the growing necessity for non-active duty beneficiaries to seek health care treatment in civilian facilities under the CHAMPUS program, many feel that there has been an erosion of what has been perceived as an important fringe benefit. A resultant reduction in morale and retention has occurred (Report, 9).

Purpose of the Study

The present environment of constrained resources in which military medicine must function has necessitated the search for alternative health care delivery mechanisms. Efforts are being directed towards improving access to care for eligible beneficiaries and shifting the financial investment away from CHAMPUS. The purpose of this study is to examine an alternative delivery system for mental health services which has the potential of resulting in a cost savings for the government.

One of the efforts designed to assist in alleviating the dual problem of access and spiralling costs is entitled Project RESTORE. This initiative was announced in 1987 by Dr. William Mayer, Assistant Secretary of Defense for Health Affairs. Project RESTORE was intended to help reverse the workload shift to CHAMPUS and contains three specific provisions ("Costs, Access", 21).

The first provision is for a CHAMPUS funding transfer. Historically, the Assistant Secretary of Defense for Health Affairs generally provided funding for CHAMPUS expenses. As a result, no incentive existed for the military services to control CHAMPUS costs. CHAMPUS expenditures for fiscal years 1986 and 1987 greatly exceeded Congressional appropriations. Partly as a consequence of this fact, the Secretary of Defense tranferred the responsibility for CHAMPUS costs to the military departments. Beginning in fiscal year 1988, the military departments pay both CHAMPUS and military treatment facility expenses from the same appropriation. This change has produced a strong incentive to control CHAMPUS costs by investing in direct patient care (Report, 14).

A second provision of Project RESTORE was to grant authority to commanders of military treatment facilities to contract with civilian health care providers for care of eligible CHAMPUS beneficiaries. These civilian providers treat the beneficiary population in the military facility ("Costs, Access", 21).

The third major provision of Project RESTORE was the requirement that the number of non-availability statements authorizing CHAMPUS inpatient be held to the fiscal year 1986 level in fiscal year 1988. The intent of this requirement was to increase the in-house level of inpatient care, thereby reducing CHAMPUS inpatient costs ("Costs, Access", 21).

Under the Project RESTORE initiative, the Military-Civilian Health Services Partnership Program was introduced. This Partnership Program is actually a revised version of the Joint Health Benefits Delivery Program (JHBDP). The program allows CHAMPUS-eligible beneficiaries to be treated on both an inpatient and outpatient basis by civilian personnel providing services in

the military treatment facility (internal partnership) and from military health care providers practicing in civilian facilities (external partnership). According to DoD Instruction 6010.12, it is the policy of DoD that the Partnership Program be utilized to intergrate civilian and military health care resources (2). Partnership agreements should be initiated by military treatment facilities that are unable to provide adequate health care services for CHAMPUS beneficiaries with resources of their own.

The CHAMPUS workload statistics for the patient population associated with the Naval Medical Clinic Annapolis, MD reveal a large number of patients treated under CHAMPUS by psychiatric specialists. In compliance with the Department of Defense and the Naval Medical Command directives, the commanding officer and staff of the Naval Medical Clinic Annapolis desire to recapture a portion of the CHAMPUS outpatient psychiatric workload by establishing an internal partnership in the Mental Health Clinic.

Statement of the Problem

The problem is to determine whether or not there is a cost advantage in establishing an internal CHAMPUS Partnership with a civilian provider for the delivery of mental health services in the catchment area of the Naval Medical Clinic Annapolis, Maryland.

Definitions

A catchment area is an identifiable geographic area surrounding a Uniformed Service MTF. Technically, it is a set of five-digit zip codes which have centers within 40 miles of the center of the zip code of the inpatient facility. The Naval Medical Clinic Annapolis is not an inpatient facility, does not

issue Nonavailability Statements, and does not, therefore, have an official catchment area as defined. For purposes of this study, the term "catchment area" is used to refer to the beneficiary population in the Annapolis and surrounding areas from which the clinic patients are drawn.

As defined by DoD Instruction 6010.12, an external partnership agreement is an agreement between the Commander of a medical facility and a CHAMPUS authorized institutional provider in which military health care providers provide treatment to CHAMPUS beneficiaries in a civilian facility.

An internal partnership agreement, as defined in the same instruction, is an agreement between a medical facility Commander and a CHAMPUS authorized civilian health care provider in which the civilian provider treats CHAMPUS beneficiaries on the premises of the military medical facility.

Objectives of the Study

1. Conduct a review of the literature in the following areas:
    a. CHAMPUS costs
    b. CHAMPUS Partnership Program
    c. Mental health care trends
2. Determine the mental health workload within the Annapolis Naval Medical Clinic catchment area that is currently referred to the civilian health care community under CHAMPUS.
3. Determine the costs associated with the CHAMPUS mental health workload.
4. Determine the type of provider and services most appropriate for a partnership arrangement in the mental health clinic.
5. Determine the projected costs of providing mental health services under a CHAMPUS Partnership established with local

civilian providers.

6. Compare costs of the present system of referral under CHAMPUS with the projected costs of delivery of mental health care under a CHAMPUS Partnership Program.

7. Make recommendations.

Criteria

An internal partnership will be considered acceptable if it will result in a projected cost savings compared to the cost of the present system of referral under CHAMPUS.

Assumptions

1. CHAMPUS data regarding workload and associated costs for mental health services will be accurate.

2. The level of demand for mental health services in the Annapolis catchment area will not change significantly in the next two years.

3. No mission changes for the Naval Medical Clinic Annapolis, which would affect the delivery of mental health services, will occur during the period of research.

4. The quality of care delivered under an internal CHAMPUS Partnership will be consistent with the care currently delivered under the traditional CHAMPUS program.

5. There is a willingness of local civilian mental health care providers to participate in a CHAMPUS Partnership program.

Limitations

1. Results of the study will be applicable solely to the catchment area of the Naval Medical Clinic Annapolis, MD.

2. Any discussions which may occur between the researcher and

potential participants in an internal partnership will not imply any commitment by the U.S. Government.

Literature Review

CHAMPUS Costs

The national health care industry has experienced sizable escalations in costs over the last few years. The military health care system has been subject to similar pressures of cost growth (Hawkes, 23).

There has been a great increase in the CHAMPUS portion of the DOD medical budget in recent years. The CHAMPUS share of the budget for fiscal year 1980 was $710 million, increasing to $1.2 billion in 1984 (Hawkes, 22). From fiscal year 1985 to fiscal year 1986, the costs for the CHAMPUS program rose from $1.3 billion to $1.7 billion. These figures indicate a 26 percent increase in a single year ("Leading Healthcare", 168). In Fiscal Year 1988, the total DoD expenditure for CHAMPUS reached $2.5 billion (Willis, 23). According to the OCHAMPUS Statistics Branch in Aurora, Colorado, in fiscal year 1989, the total DOD CHAMPUS bill was $ 2.36 billion. The fiscal year 1990 costs to date are $2.57 billion. For fiscal year 1990, a cost overrun of approximately $750 million will be experienced. The original CHAMPUS budget for fiscal year 1990 was $2.4 billion (Nelson, 1). A graphical representation of the DOD CHAMPUS cost figures is provided in Appendix B. CHAMPUS costs associated with treating Navy and Marine Corps beneficiaries were $465 million in 1984. By the end of fiscal year 1988, the costs for these beneficiarie had risen to $903 million (Matthews, 43). This $903 million equated to a $261 million budget overrun (Matthews, 43).

The total Navy budget for medical and dental services for fiscal year 1988 was $3.6 billion, representing 4 percent of the Navy Total Obligation Authority (Report, 3). The OCHAMPUS Statistics Branch states that the fiscal year 1989 and 1990 Navy Champus costs were $890 million and $967 million (to date), respectively. These Navy CHAMPUS cost figures are depicted in Appendix C.

Teresa Hawkes, Director of the Office of the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS), suggests that the military health care system is influenced by factors which make exerting control over rising costs more difficult:

1. There are approximately 10 million beneficiaries who are located throughout the world and move frequently.
2. The existence of the dual missions; to provide peacetime health care and to maintain readiness.
3. There are three distinct military health care systems in addition to the CHAMPUS program.
4. CHAMPUS has been forced to operate within its present resources. As a result, there are very little resources available for experimentation with innovative cost-saving alternatives (Hawkes, 23).

An article appearing in Hospitals journal contains the assertion that the significant rise in CHAMPUS costs in recent times is due to the failure of the CHAMPUS program to adopt cost-containment strategies as private payers and other government payers have done ("Providers Eye", 22). For the period from 1983 through 1986, costs associated with the CHAMPUS program demonstrated a rate of increase that was 50 percent faster than total U.S. health care costs ("Leading Healthcare", 168). This assessment may have some validity, however, a

majority of the rise in costs must be attributed to the tremendous increase in usage of the CHAMPUS program. For the Navy and Marine Corps alone, the number of beneficiaries using the CHAMPUS entitlement nearly doubled from 1982 to 1988 (Matthews, 43).

According to Hawkes, one of the goals of cost containment efforts currently in effect at OCHAMPUS is to return CHAMPUS to its original role as a complement to the direct care systems of the military services. In recent times, over 63 percent of CHAMPUS dollars for inpatient care were spent for families living in the catchment areas of military hospitals (Hawkes, 31).

CHAMPUS Partnership Program

An extensive review of the literature revealed very little published information regarding the CHAMPUS Partnership Program. One article located in the Military Medicine journal ("The Joint Health Benefits Delivery Program: Improving Access and Reducing Costs-Successes and Pitfalls") did relate the implementation and results of a program established in an Army community hospital (Segal and Bellamy, 430).

In an effort to curtail rising CHAMPUS costs, the staff of the Moncrief Army Community Hospital (MACH) decided to implement an agreement with civilian providers under the Joint Health Benefits Delivery Program (JHBDP - recently renamed the Partnership Program). Several specialty services for which the JHBDP exhibited potential were considered. The specialties of oncology, cardiology, and pulmonary medicine were initially targeted for further consideration, based primarily on review of the issuance of Nonavailability Statements for these services. Oncology care was ultimately chosen, as it seemed to generate the

most interest in the part of beneficiaries and offered a larger number of prospective patients (Segal and Bellamy, 431).

Three university faculty physicians were chosen as providers for oncology care. MACH appointed an oncology nurse from its staff to provide the necessary nursing care. The facility designated a segment of clinic space dedicated for outpatient oncology care and for providing chemotherapy treatment. An underutilized internal medicine ward had beds which were reassigned for oncology inpatient care (Segal and Bellamy, 431).

According to Segal and Bellamy, the program was favorably received by both patients and their families. The program provided access to services close to home and care was received in surroundings which were familiar and comfortable. Additionally, patients were able to avoid the costs associated with civilian care (431). Evidence of patient acceptance of the program is provided by the enrollment statistics. More than 200 patients were enrolled during the first nine months of the program. Thereafter, new patients presented at a rate of seven to ten patients per month (Segal and Bellamy, 431).

As shown in Table 1 below, a comparison of costs between the new program at MACH and care provided at a local civilian hospital reveal a vast difference in charges.

Table 1

Comparison of One Week Oncology Care

(with Chemotherapy)

	HOSPITAL X	MACH
Hospital Charges	$4,500	$ 51*
Drug Charges	980**	0
Physician Charges	305***	280
Total Charges	5,785	331

* Assuming $7.30 per day

** Average figure; range from $182 to $1820 per week

*** Admission examination $125, $30 daily thereafter

(Segal and Bellamy, 431)

The cost share for the beneficiary decreased from $1,446 to $121 and the CHAMPUS cost decreased from $4,339 to $210 (Segal and Bellamy, 431). It must be noted here that at the time of the MACH initiative, the program was still operating as the Joint Health Benefits Delivery Program. Since the program was re-introduced as the Military-Civilian Health Partnership Program under Project RESTORE, the CHAMPUS beneficiary copayment has been eliminated for this type of internal partnership, further reducing costs.

Segal and Bellamy assert that this program has tremendous potential in the appropriate situations. They define the appropriate situations as "unmet specialty needs, significant costs differentials between military and civilian care, specialty physicians of high caliber willing to practice within a military

facility, and sufficient facility capacity and resources to underwrite these efforts" (431).

Segal and Bellamy advise that any facility instituting a program such as the one at MACH should be prepared to assess the number of potential patients in the specific specialty and the competition for these patients among the local area civilian facilities as well as other military facilities in the region. They also advise that a survey should be conducted to ensure the existence of a significant cost advantage and, therefore, an incentive to utilize this option (431).

Mental Health Care Trends

In recent years, the number of claims and associated costs for mental health care have risen significantly for many employers, including the government (Trauner, 28). This is partly a reflection of improved access to mental health services and increasing public awareness and acceptance of these services. Prudent purchasing of mental health services has become an important issue (Wenzel, 39). Controlling rising mental health care costs is an especially high priority for the military due to the fact that mental health care is a major consumer of CHAMPUS funds. In Fiscal Year 1988, mental health care claims accounted for 21 percent of the $2.5 billion total CHAMPUS cost (Willis, 23).

In response to this high cost trend for psychiatric treatment, employers and insurers have sought methods for cost control ranging from restriction of benefits to implementation of case management systems. Most efforts to address the costs of psychiatric benefits have adhered to the basic principles of not expanding benefits and attempting case management for inpatient,

not outpatient, care (Bender, 36). Bloomingdale's department store chain, however, countered this trend and has experienced favorable results (Bender, 36).

Bloomingdale's sought the services of a mental health consulting firm to assist in restructuring mental health benefits to a plan that would offer a broad range of care in a cost effective manner. The plan proposed by the consulting firm did not disallow any benefits based on diagnosis or type of provider and focused on the management of outpatient care (Bender, 36).

In order to encourage use of providers in the preferred provider network for the plan, any employee who received care from network providers was not required to pay the usual deductible. Employees were given the option of selecting non-network providers while still maintaining the normal benefit, but were required to pay the deductible (Bender, 36).

Bloomingdale's expected a high utilization rate for the program of expanded benefits. Orientation was provided for employees and educational material describing the program were distributed. Full use of this benefit was encouraged (Bender, 38).

Providers selected for participation in the program were required to sign an agreement stating that they would be available for orientation and training. Appointments had to be offered within a specific period of time whenever requested and designated reports were required to be submitted by established deadlines. In addition, there was an understanding that providers would be held accountable to the staff of the consulting firm conducting health care utilization reviews (Bender, 38).

Analysis of the program for the first year of operation

showed significant cost savings compared to the previous year. Specifically, the cost differential for an outpatient course of treatment was approximately $1200 per patient. No hospitalizations were ordered by the network providers. In contrast, nonparticipating providers ordered 18 hospitalizations totalling roughly $95,000. Bloomingdale's plans to encourage more employees to utilize services within the network by offering free second opinions for outpatient treatment (Bender, 38).

A preferred provider organization, such as the one briefly described in the Bloomingdale's case, is defined as any arrangement between a group of providers and purchasers that will channel patients to the participating providers (Merz, 33). Typically, a negotiated arrangement with participating providers includes special access and discounted rates (Wenzel, 42). Employers and insurers have been increasingly willing to consider managed care programs, such as PPO's, as alternative approaches for delivering mental health services due to their cost containment potential (Trauner, 32).

Wenzel recommends that mental health services can be managed most effectively with the use of brokers. He defines the function of a broker as being to ensure that the purchase of health care occurs in a cost-effective manner (41). Wenzel states that brokers of mental health care should be reimbursed for their services by the purchaser, as they should represent the interests of the customer and the payer (40). Brokers and PPO's can exist simultaneously. A broker may be needed to assist in the selection of the best provider for a patient within the network of preferred providers (Wenzel, 44).

The concept of such a managed care program can be successfully applied to the military health care system. In the

military system, however, the government must fill the role of both payer and broker. The CHAMPUS Partnership Program represents an innovative attempt at approaching a system of managed care at the individual facility level. Such attempts are necessary to address the current problem of patient self-selection of providers, with no links between the military and CHAMPUS systems. By maintaining closer management of patients as opposed to total disengagement under standard CHAMPUS, CHAMPUS Partnerships can facilitate more efficient operations.

CHAMPUS Mental Health Care Benefits

CHAMPUS provides coverage for both outpatient and inpatient mental health care. For outpatient treatment, CHAMPUS will cost-share one, one-hour psychotherapy session per day with a limit of two sessions per week. For inpatient treatment, CHAMPUS will cost-share one, one-hour session per day for up to five sessions per week. Care beyond these limits may be covered in certain cases, provided a medical necessity exists (CHAMPUS Handbook, 35). Inpatient stays are covered for a maximum of sixty days per calendar year. CHAMPUS may provide extended coverage for extraordinary medical or psychological reasons (CHAMPUS Handbook, 35). Mental health care provided under CHAMPUS is subject to periodic reviews which may result in delays in the processing of claims (CHAMPUS Handbook, 36).

Recently, CHAMPUS began cost-sharing biofeedback services as a part of the mental health care coverage. As stated in CHAMPUS News, coverage for biofeedback is limited to the following medical conditions:

- Raynaud's Syndrome
- Severe muscle spasm, weakness, or abnormality (1).

Coverage for biofeedback treatment for these conditions is limited by CHAMPUS to a maximum of 20 treatments each calendar year, including both inpatient and outpatient care (CHAMPUS News, 1).

As of December 1, 1988, CHAMPUS reimbursement for residential treatment center (RTC) care is based on an all-inclusive facility specific per diem rate ("RTC Payment", 2). The rate, which is established by OCHAMPUS, encompasses the RTC's daily charge for all inpatient care and mental health treatment determined necessary and rendered as part of the treatment plan, as authorized by the American Psychiatric Association ("RTC Payment", 2). The rate includes the following:

- Individual and group psychotherapy
- Collateral visits with individuals as determined necessary to gather information or implement treatment goals
- Family therapy for parents within 250 miles of the facility
- All other ancillary services provided by the facility ("RTC Payment", 2).

In order to be an authorized CHAMPUS provider, an RTC must sign a participation agreement requiring the RTC to accept the CHAMPUS per diem rate as payment in full for care specified in the agreement ("RTC Payment", 2).

Methodology

1. A literature review was conducted to ascertain recent trends and developments in the areas of CHAMPUS costs, the CHAMPUS Partnership Program, and mental health care services.
2. Department of Defense and Naval Medical Command instructions were reviewed to determine guidelines established for instituting CHAMPUS internal partnerships.
3. CHAMPUS summary report data for mental health services for the Annapolis catchment area was obtained for the past two years and reviewed to determine the recent workload for referrals to the civilian health care providers.
4. Expenditures for the past two years for mental health services were examined to determine the costs associated with the workload referred to the community.
5. Discussions were conducted with the Mental Health Clinic staff and with the Health Benefits Advisor to determine the most appropriate category of provider and type of service to seek in establishing a CHAMPUS internal partnership.
6. Costs of providing the projected workload of mental health services were calculated based on potential negotiated percentages of the applicable CHAMPUS prevailing rates for the services involved.
7. A cost analysis was performed comparing costs for the present system of referral under CHAMPUS with the projected costs of delivery of mental health care under a CHAMPUS internal partnership.
8. Recommendations were made based upon the findings of the study.

CHAPTER II

DISCUSSION

Review of Instructions

DoD Instruction 6010.12 and Naval Medical Command (NAVMEDCOM) Instruction 6320.29 together provide the guidelines for establishment and implementation of CHAMPUS Partnerships. These guidelines relate to both policies and procedures.

Potential applications of the Partnership Program should be analyzed on a case-by-case basis (DoD Instruction, 3). The DoD Instruction specifies that it is the responsibility of the MTF commander to ensure that a partnership agreement does not compromise the mission of the facility, and that the resources to be provided are generally consistent with those resources generally provided by the MTF (4). Health care resources which are eligible for inclusion in the Partnership Program are health care providers, support personnel, equipment, and supplies (DoD Instruction, 2).

As outlined in NAVMEDCOM Instruction 6320.29, unique features of the CHAMPUS Partnership Program include:

- No CHAMPUS beneficiary copayment or deductible requirements (internal partnerships)
- Provision for the treatment of non-CHAMPUS-eligible beneficiaries by using MTF supplemental care funds
- Potential to implement a partnership agreement within 90 days of request submission (1)

Partnership requests must be submitted to the appropriate geographical commands (GEOCOMs) for initial conceptual concurrence (NAVMEDCOM Instruction, 3). A sample of internal partnership request elements is provided in Appendix D.

NAVMEDCOM Instruction 6320.29 requires that GEOCOMs issue concurrence or nonconcurrence to requests within 10 working days of receipt (3).

All potential partnership participants in the area of the MTF must be given a fair opportunity to participate in a proposed partnership agreement. Objective selection criteria must be used, including:

- Professional qualifications of the provider
- Availability
- Proposed partnership rates (NAVMEDCOM Instruction, 3).

A memorandum of understanding (MOU) and a partnership fee schedule must be completed by the MTF when negotiating an internal partnership agreement (NAVMEDCOM Instruction, 4). A sample MOU and a sample partnership fee schedule are provided in Appendices E and F, respectively.

The terms of each MTF negotiated MOU and fee schedule will be evaluated by the GEOCOMs, who must issue concurrence or nonconcurrence within 15 working days of receipt. The partnership package, including the GEOCOM letter of concurrence, will then be forwarded to the cognizant CHAMPUS fiscal intermediary for implementation approval (NAVMEDCOM Instruction, 4).

A partnership agreement may be established for a maximum period of 2 years, with an option to renew for up to an additional 2 years (DoD Instruction, 5). A sample partnership agreement renewal form is provided in Appendix G.

CHAMPUS Mental Health Care Summary Report Data

As previously discussed, the Naval Medical Clinic Annapolis is not technically associated with a specific catchment area. Consequently, CHAMPUS Health Care Summary Reports do not identify data for this clinic. In order to obtain the cost and workload information required for this study, a Special Area Report was requested. With the assistance of the Health Benefits Advisor (HBA), specific zip codes for the Annapolis and surrounding areas were identified and submitted to the OCHAMPUS Statistics Branch. Using the zip codes as a basis to sort the available data, the Statistics Branch was able to generate CHAMPUS Health Care Summary Reports for the Naval Medical Clinic Annapolis.

CHAMPUS Health Care Summary Reports were provided for Fiscal Years 1987 and 1988. These reports were generated using 24-month and 18-month collection periods and are considered by OCHAMPUS to be 100 percent and 96 percent complete, respectively.

The reports contain the workload and costs for outpatient mental health services in the Psychiatry Groups I and II. These groups are based on the International Classification of Diseases (ICD-9-CM) Diagnoses Codes (see Appendix H). No breakouts by treatment codes could be provided.

Data from the CHAMPUS Health Care Summary Reports is provided in Table 2 below:

Table 2

CHAMPUS HEALTH CARE SUMMARY

	FY 1987		FY 1988		% CHANGE	
	Group I	Group II	Group I	Group II	Group I	Group II
Users $	330	171	306	337	- 7%	+ 51 %
# Visits	3,026	824	4,516	3,686	+ 49%	+ 347 %
Govt. Cost	145,204	42,348	232,840	185,719	+ 60 %	+ 339 %
Patient Cost	69,774	22,688	102,640	87,414	+ 47 %	+ 285 %
Total Cost	214,978	65,036	335,480	273,133	+ 56 %	+ 320 %
Avg. Govt. Cost/Visit	47.99	51.39	51.56	50.38	+ 7 %	- 2 %

The percentage of change in the figures for Group I and Group II from FY 1987 to FY 1988 were calculated by the researcher. As shown in the above table, great increases in both volume of patient visits and patient and government costs occurred during this time. The largest increases in both volume

and costs were experienced in Group II. Average government cost per visit for Group II, however, actually decreased 2 percent. The average government cost per visit for Group I increased 7 percent. A meaningful trend analysis could not be accomplished based on the availability of only 2 years of data.

The total costs and number of visits for each fiscal year for Groups I and II combined are summarized below:

	FY 1987	FY 1988	% CHANGE
Total Costs	$ 280,014	608,613	117 %
Total # Visits	3,850	8,202	113 %

Mental Health Clinic

Organization

The Mental Health Clinic at the Naval Medical Clinic Annapolis is staffed with the following personnel:

1 Clinical Psychologist
1 Social Worker
1 Secretary

The psychologist, head of the department, is an active duty Medical Service Corps officer. The social worker (an MSW) and the secretary are both Civil Service employees. The present social worker came on board in August of 1988. Prior to that time, there was no social work position in the clinic.

The Mental Health Clinic organizationally is a part of the Directorate for Medical Services.

Mission

The purpose of the Mental Health Clinic is to provide consultative services for eligible active duty, retired, and dependent beneficiaries referred from staff providers for psychological evaluation, treatment, and for further therapeutic recommendations regarding disorders, adjustment reactions, and organic impairments. The clinical psychologist is available for liaison with the Midshipmen Counseling Center at the Naval Academy.

Workload

According to the psychologist, and as reflected in the monthly workload data for the clinic, approximately 90 percent of all patients seen in this clinic are active duty status. Much of the psychologist's time is spent dealing with patients who require fitness for duty assessments, administrative separations, and with active duty support groups.

Approximately 80 percent of the patients seen are referred from other Naval Medical Clinic staff providers. The other 20 percent are self-referrals or are referred by their commanding officer, if active duty. The current average waiting time for an appointment is 2 weeks.

For workload reporting purposes, all clinic visits with the psychologist are reported under the Uniform Chart of Accounts (UCA) code BFDA. All visits with the social worker are reported under the UCA code BFEA. Workload totals for the Mental Health Clinic for the period from October through May FY 1989 were as follows:

BFDA	612
BFEA	1873

The social worker is the Family Advocacy Representative for the command and the majority of her time is spent dealing with the Family Advocacy Program. The workload statistics for BFEA are much greater than for BFDA due to a lesser intensity of services and due to a large number of telephone consultations which are counted as clinic visits.

Potential Partnership - Provider and Services

Discussions were conducted with the Mental Health Department Head and with the CHAMPUS Health Benefits Advisor (HBA) to ascertain the type of provider and type of services that would be most beneficial to pursue for a CHAMPUS Partnership. Both the HBA and the department head concurred that a clinical psychologist specializing in adolescent and child therapy would offer the most benefit to the clinic at this time.

Once a type of provider and services were identified for a potential CHAMPUS Partnership, it was necessary to address several other issues. One issue to consider was the availability of clinic spaces to accomodate an additional provider. The Mental Health Clinic had to physically relocate to different spaces earlier this year as a result of special renovations projects which were underway. The department head felt that the current spaces, though not ideal, could be reconfigured in such a way that adequate space would exist for an additional provider. This rearrangement to provide a vacant office could be accomplished at a negligible cost.

Another factor to consider was whether it would be necessary to include non-CHAMPUS eligible beneficiary services in the Partnership Agreement. Since all adolescents and children who are eligible for military health care benefits are eligible for

CHAMPUS as well, no need exists to make provisions for non-CHAMPUS eligible patients to be treated under a Partnership Agreement for adolescent/child therapy.

The potential impact of a CHAMPUS Partnership on ancillary services (laboratory, radiology, and pharmacy) was another factor that needed consideration. All parties agreed that the impact on ancillary services would be minimal, with no need for additional staffing or other resources in those areas.

The only area in which it was felt by all parties concerned that a significant impact would occur was administrative support. Currently, the one secretary in the Mental Health Clinic providing clerical support is insufficient for the clinic needs. The recent addition of the social worker has had a tremendous impact on the amount of clerical work generated in the clinic. Adding another provider would increase the administrative workload beyond the capacity of one clerical employee, particularly since a CHAMPUS Partnership Provider requires submission of CHAMPUS claim forms. With the establishment of a CHAMPUS Partnership, supplemental clerical support will need to be provided.

Cost Analysis

Projected Partnership Workload and Costs

The staff of the Mental Health Clinic felt that any negotiated Partnership Agreement should specify a workload of 5 patient visits a day for 3 days each week, for a total of 15 patient visits per week. This workload estimate is based on 50 minute psychotherapy sessions. With 15 patient visits per week, the annualized total number of visits would equal 780. It was

felt that the chances of getting a psychologist to participate in a part time agreement which would supplement his or her regular practice was more feasible than trying to obtain someone for a full schedule.

The CHAMPUS Prevailing Rate for a 50 minute outpatient psychotherapy session rendered by a clinical psychologist is $85.00 in the state of Maryland. The Prevailing Rates from Fiscal Year 1987 were still in use at the time of this study, as Congress had not yet approved a more current fee schedule.

The cost to the government for the established potential partnership workload, if provided under traditional CHAMPUS, can be calculated using the following formula:

CHAMPUS Prevailing Rate	-	Patient Cost Share	X	Projected Workload	=	Net Cost to Government

Based on the Prevailing Rate of $85.00, patient cost share of 20 percent, and the established workload of 780 visits, the resulting cost to the government is $53,040. The patients' portion of the cost is $13,260, for a total cost of $66,300.

The formula used for calculating potential costs savings to the government is as follows:

CHAMPUS Prevailing Rate	-	Negotiated Partnership Rate	-	Patient Cost Share	X	Projected Partnership Workload

= Net Savings to Government

CHAMPUS, under the traditional program, is responsible for 80 percent of the Prevailing Rate while the patient is responsible for the remaining 20 percent. Any negotiated CHAMPUS Partnership rate represents a percentage of the 80 percent normally payable by CHAMPUS. No patient cost share is ever applicable under an internal partnership agreement.

Potential negotiated partnership rates and the corresponding net savings to the government are given below:

Table 3

Calculated Net Savings

Negotiated Rate	Government Cost	Net Savings to Government
100 %	$ 53,040	$ 0
95 %	50,388	2,652
90 %	47,736	5,304
85 %	45,084	7,956
80 %	42,432	10,608
75 %	39,780	13,260
70 %	37,128	15,912

At all potential negotiated partnership rates for an internal partnership, a cost savings of $13,260 will be realized for the patients involved.

According to a Naval Medical Command point of contact for the CHAMPUS Partnership Program, the Navy has no requirements for

specific negotiated rates that must be achieved for partnership approval. A negotiated rate of 100 percent may be accepted if it includes such items as supplies or equipment. The Navy also recognizes the public relations value of the patient cost savings at all negotiated rates. As stated previously, for the purposes of this study, an internal partnership will be acceptable if it will result in a projected cost savings to the government compared to the cost of the present system of referral under CHAMPUS.

CHAPTER III

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

The problem was to determine the cost advantage of establishing an internal CHAMPUS Partnership with a civilian provider for the delivery of mental health services in the catchment area of the Naval Medical Clinic Annapolis, Maryland.

The cost advantage to the government, at each potential negotiated rate, was provided in Table 3. However, the need for additional administrative support must also be considered. In view of this fact, several alternatives become apparent, as outlined below:

Alternative 1

Do not establish an internal CHAMPUS Partnership in the Mental Health Clinic.

Alternative 2

Establish an internal CHAMPUS Partnership in the Mental Health Clinic at a 90 to 100 percent negotiated rate (or whatever terms are acceptable), requiring provision of administrative support by the participating provider.

Alternative 3

Establish an internal CHAMPUS Partnership in the Mental Health Clinic at the lowest possible negotiated rate, with the necessary administrative support provided by the facility (military or civilian personnel).

Discussion of Alternatives

If Alternative 1 is selected, the cost savings to the patients will be foregone, along with any associated increase in patient satisfaction and the perception of goodwill. All patients will continue to self-select civilian providers, and no steps toward increased patient management will be made.

Selection of Alternative 2 would not completely meet the need for increased administrative support, as some administrative functions must be accomplished by MTF personnel. These functions include monitoring of partnership claim submissions and maintenance of credentials files. Also, there may not be enough incentive for a provider to accept a reduced rate, lose the patient cost share, and provide administrative support.

Pursuit of Alternative 3 would require hiring a Civil Service employee, as the current level of military staffing is not sufficient to allow assignment of a military member to the Mental Health Clinic for this purpose. According to the Federal Pay Schedule for Salaried Employees (as stated by the Civilian Personnel Coordinator at the Naval Medical Clinic Annapolis), the annual salary for a GS-3, step 1 clerical position is $12,038. Assuming additional costs (beyond salary) of 11 percent for taxes and benefits, the approximate total cost for hiring a clerical support person would be estimated at $13,362 annually. If a negotiated rate of 70 percent could be obtained, an overall cost savings for the government of $2550 would be realized ($15,912 net savings from Table 3 less $13,362 for administrative support). The government savings of $2550 combined with the patient savings of $13,260 results in an overall savings of $15,810.

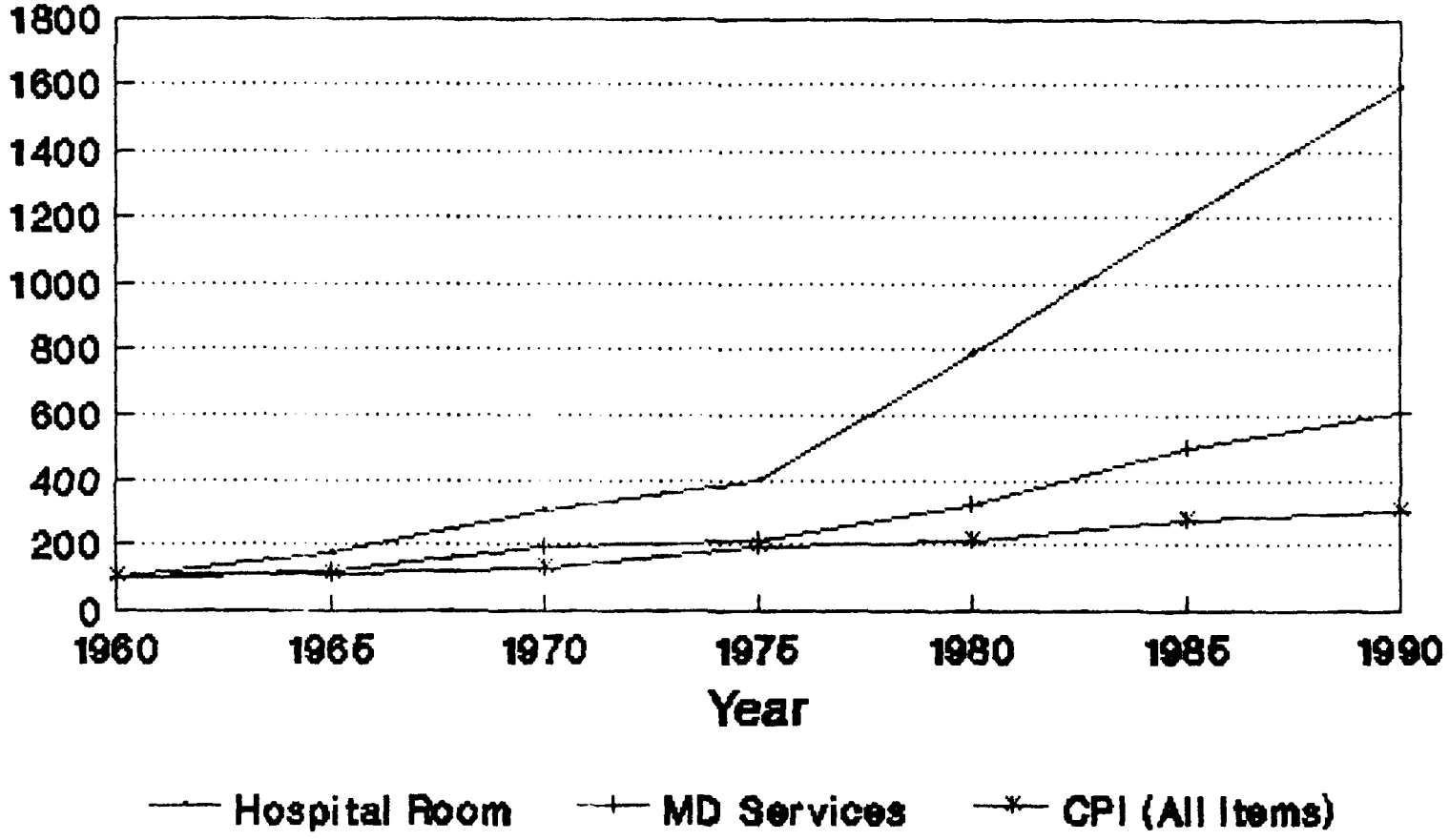
Recommendations

Based on the results of this study, it is recommended that an internal CHAMPUS Partnership be established with a civilian provider for the delivery of adolescent/child psychology services at the Naval Medical Clinic Annapolis, Maryland. This recommendation is contingent upon the ability to negotiate a rate of 70 percent, and the ability to hire a GS-3 employee to provide administrative support.

In addition to the overall cost savings of $15,810 which will be attained, the Naval Medical Clinic Annapolis should benefit from an enhanced patient satisfaction in the associated beneficiary population. Another benefit to the Naval Medical Clinic will be the eventual increase in resources commensurate with the increased workload reported.

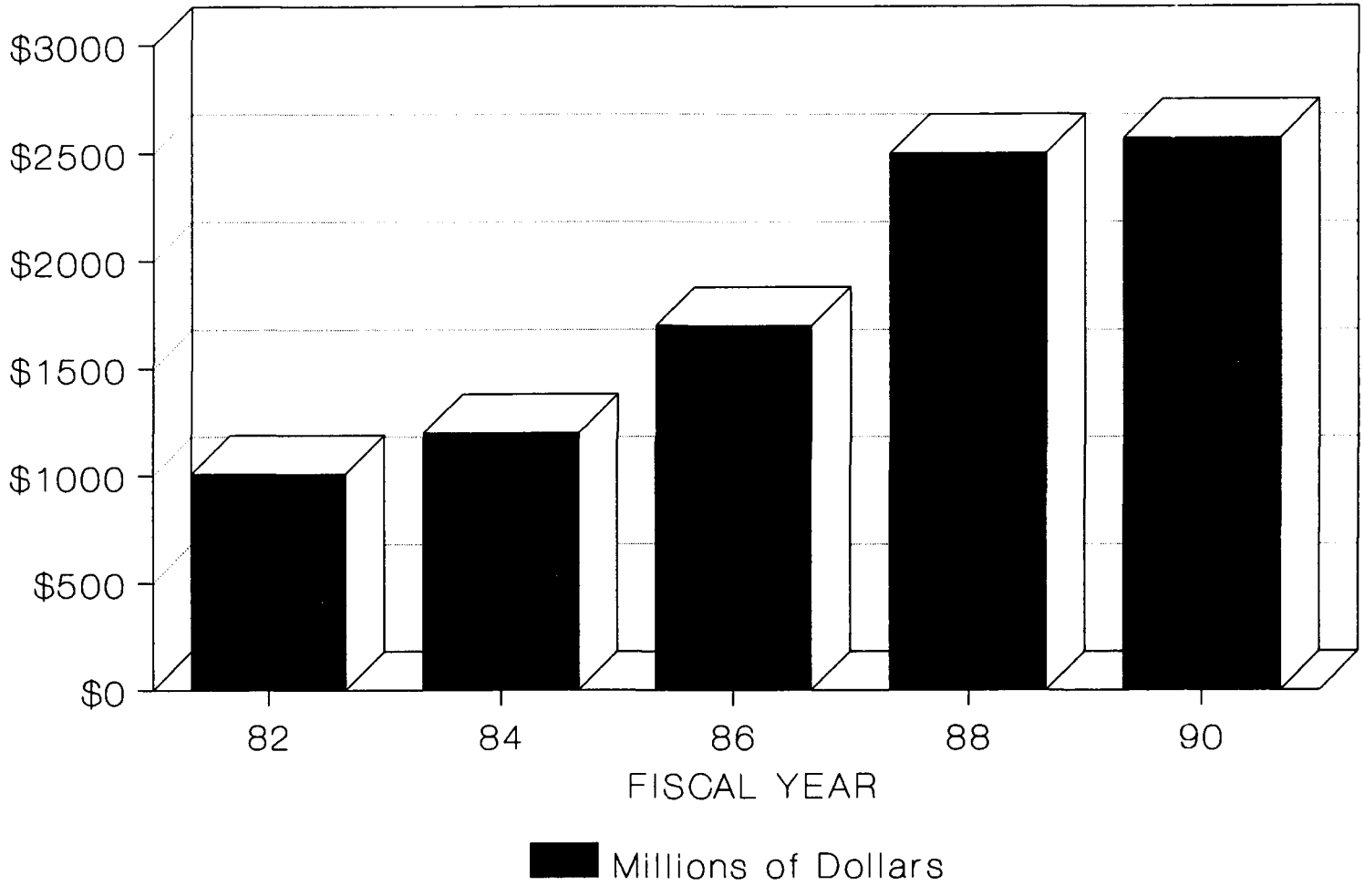
Once an initial CHAMPUS Partnership is established in the Mental Health Clinic, the administrative support functions will be in place. An additional partnership in the same clinic, with a similar workload, could be implemented. Without the offset of additional administrative support, greater incremental cost savings could be achieved.

MEDICAL COSTS and CPI
CY 1960 Through 1990 (Projected)

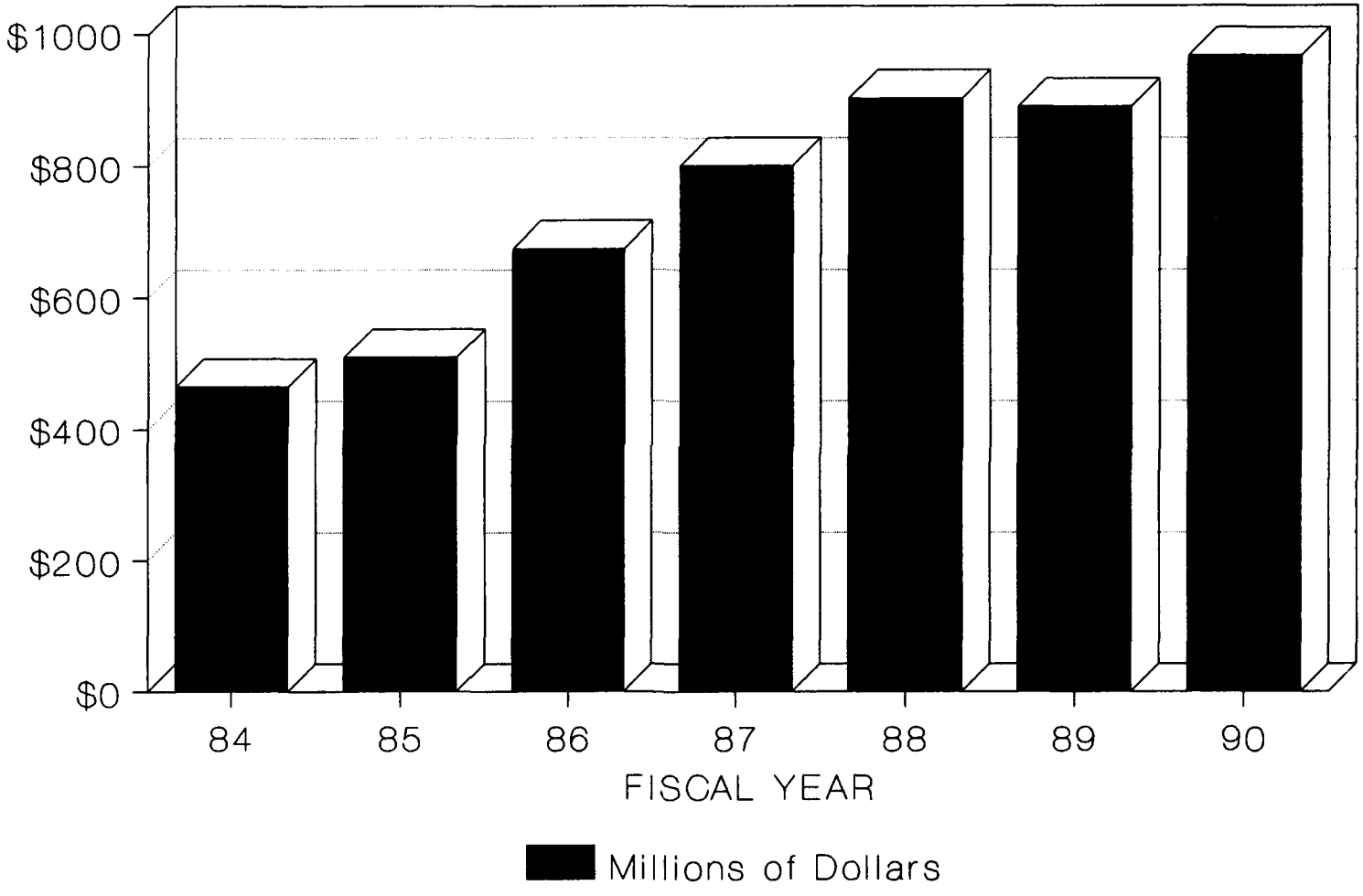


Price Index for 1960 = 100

DoD CHAMPUS COSTS



NAVY CHAMPUS COSTS



APPENDIX D

SAMPLE INTERNAL PARTNERSHIP REQUEST ELEMENTS

1. Partnership requests should include the following minimum elements:

a. Information Requirements for Conceptual Concurrence

(1) The number and types (specialties) of partnership providers requested and their anticipated full or part-time status. MTFs may consolidate multiple requests for partnership providers in a single request letter.

(2) The MTF name, location and department where the partnership provider(s) will be working. Briefly address the adequacy of the clinic space, ancillary services, support personnel

and equipment for each request. Identify and justify any proposed support staff, equipment, or supplies to be provided by the partnership provider.

(3) Brief description of the need for, appropriateness, and potential cost effectiveness of each partnership request. Briefly note the reasons for using a partnership agreement as opposed to other potential alternatives, such as VA/DOD sharing agreements. Ifimplementation of the request is expected to require exceeding theCHAMPUS prevailing rate, indicate how this additional cost will bepaid for by the MTF.

(4) Whether active duty or other non-CHAMPUS-eligible personnel will need to be treated on a regular, nonemergency basis

by the partnership provider. If so, provide justification and anticipated sources of payment.

(5) Whether the partnership request as specified can be implemented without additional MTF resources.

(6) Any additional pertinent information.

(7) The name and telephone number (both AUTOVON and commercial) of the MTF POC for the partnership request.

b. Requirements for Final Review and Concurrence:

(1) Above information, revised as appropriate.

(2) A fully completed and signed partnership MOU.

(3) A signed partnership fee schedule.

(From NAVMEDCOM Instruction 6320.29)

APPENDIX E

SAMPLE PARTNERSHIP MEMORANDUM OF UNDERSTANDING

BETWEEN THE NAVAL MEDICAL CLINIC ANNAPOLIS AND _____

_____ CITY OF _____ STATE _____.

1. General

a. This agreement is entered into by and between the Naval Medical Clinic Annapolis, MD herein referred to as the medical treatment facility (MTF), and _____ herein referred to as the participating provider.

b. The purpose of this agreement is to integrate specific mental health services for CHAMPUS beneficiaries in the Naval Medical Clinic Annapolis.

c. The participating health care provider is licensed to practice medicine in the State of _____ and has completed application for clinical privileges at the MTF for the purpose of practicing medicine in _____. The participating health care provider agrees to all the terms and conditions of the application for clinical privileges at the MTF, as well as the terms and conditions of this Memorandum of Understanding.

d. The MTF is a U.S. Government health care facility within theDepartment of Defense (DOD) operated by the U.S. Department of the Navy. The MTF is accountable to the Commander, Naval Medical Command, as the equivalent of the Board of Trustees. The

commanding officer of the MTF is the local representative of the Board of Trustees and is responsible for the operation of the MTF.

2. Articles of Agreement

a. The Commanding Officer of the MTF, or designee must:

(1) Review past and current performance of, determine qualifications of (including review of liability insurance coverage) and select participating health care providers using objective selection criteria.

(2) Comply with the utilization review and quality assurance directives and regulations of the Department of the Navy, including but not limited to:

(a) Ensuring that participating health care providers are privileged following DOD and Department of the Navy regulationns
and the MTF bylaws.

(b) Ensuring that participating health care providers adhere to the Department of the Navy and MTF bylaws, and DOD and Department of the Navy regulations to the same extent and in the same manner as other Department of the Navy health care providers.

(3) Provide facilities, ancillary support, diagnostic and therapeutic services, equipment, and supplies necessary for the proper care and management of patients under this agreement, to the extent available and authorized for the MTF.

(4) Provide administrative support to participating health care providers, to the extent available and authorized for the MTF, including:

(a) Maintenance of patient records, including transcription and copying service, as necessary to satisfy both Department of the Navy and private practitioner recordkeeping requirements.

(b) Maintenance of participating health care provider case, workload, and credentialed files in support of privileging processes.

(c) CHAMPUS administration requirements, including certification and submission, but only to the extent that it is not prohibited by 18 U.S.C. 203 and 205.

(d) Ensure that partnership claims are correct. MTFs must implement a system for conducting periodic audits of partnership records, including review of CHAMPUS explanation of benefits (CEOB) statements.

(e) Provide accomodations within the MTF for such periods of time as the participating health care provider may be on after-hours call.

(f) Authorize subsistence at MTF dining facilities at rates prescribed for civilian guests.

(5) Identify a MTF partnership point of contact (POC) to

advise participating health care providers about partnership administrative matters.

(6) Educate Navy MTF staff personnel, beneficiaries, participating health care providers, and other interested civilian providers about the Partnership Program.

b. The Participating Health Care provider must:

(1) Provide and monitor outpatient medical care services to CHAMPUS-eligible beneficiaries referred by the MTF under this agreement.

(2) Be a CHAMPUS-authorized health care provider, and agree to treat CHAMPUS-eligible beneficiaries at the partnership agreement rates negotiated with the MTF, using the facilities and other resources provided by the MTF.

(3) Be on duty at the MTF for the treatment of partnership patients for a minimum of _____ (days and hours per week) and agree to extend these hours as necessary to ensure completion of scheduled patient treatment. Planned absencesmust be requested in writing with fifteen days advance notice to the MTF partnership POC for approval.

(4) Agree not to collect CHAMPUS copayments and deductibles from CHAMPUS-eligible beneficiaries treated under this agreement.

(5) Meet the licensing and privileging requirements of the

MTF (per NAVMEDCOMINST 6320.8 and DOD Directive 6025.2). Services may not be provided under this agreement until clinical privileges have been granted by the commanding officer of the MTF, and permission has been received to implement this agreement.

(6) Provide full disclosure of all information, including but not limited to past performance as required by the privileging process.

(7) Use all available Department of the Navy resources including specialty consultations, MTF ancillary services, support personnel, equipment, and supplies for the optimal care of patients under this agreement.

(8) Provide the following support personnel, equipment, and supplies _____ as required under this agreement.

(9) Provide full professional liability insurance covering acts or omissions of such participating health care provider, as well as those support personnel not covered by 10 U.S.C. 1089, and other resources supporting that provider as part of this agreement, to the same extent as is usual and customary in civilian practice in the community.

(10) Provide personal liability coverage applicable to clinical privileges granted with indemnification of the U.S. Government as a third party beneficiary.

(11) Abide by MTF rules, regulations and bylaws; adhere to DOD and Department of the Navy regulations with regard to

utilization review and quality assurance directives, including but not limited to inservice training, maintenace of records, utilization review, performance evaluation, release of medical information, and privileging.

(12) Abide by unique Department of the Navy requirements concerning the nature of limited privileged communication between patient and health care provider as necessary for security and personnel reliability programs.

(13) Agree never to advise, recommend, or suggest to individuals authorized to receive health care under the partnership agreement, that such individuals should receive care from the participating provider when he or she is not on duty, or from a partner or medical group associated in practice with the provider, except with the express written consent of the commanding officer of the MTF. The participating health care provider is not prohibited, by reason of his or her performance under this agreement, from outside employment so long as there is no conflict with the performance of services under this agreement. The provider may not use any Government facilities or other government property in connection with outside employment.

(14) Adhere to partnership rates negotiated with the MTF, and all CHAMPUS FI and MTF claim submission requirements; and agree to periodic audits of partnership records by the MTF to validate the accuracy of partnership claims.

(15) Agree to stamp the word "Partnership" on the front of each partnership claim form completed (in large letters at the top

of the page in red ink) before submitting the claim as instructed by the MTF.

(16) Agree to obey all applicable MTF requirements, including avoiding the waste of MTF utilities, and not using Government telephones for personal business. All motor vehicles operated on the MTF installation must be registered with the base security service per applicable directives. Eating and smoking are prohibited in patient care areas and are restricted to designated areas.

(17) Agree to be neat, clean, well-groomed, and in appropriate clothing when in patient care and public areas. The participating health care provider must display an identification badge on the right breast of his or her outer clothing which includes the provider's full name and professional status. All clothing must be free of visible dirt and stains, and must fit correctly. Fingernails must be clean and free of dirt, and hair must be neatly trimmed and combed.

(18) Be able to speak, read, write, and understand the English language fluently.

c. Other Considerations

(1) This signed and dated agreement is not effective until approved by both the geographic naval medical command (GEOCOM) and the CHAMPUS FI (by means of written notification to the MTF and the participating health care provider).

(2) Neither party may assign, transfer, convey, sublet, or otherwise dispose of this agreement, to any other person, company, or corporation, without the other party's previous written consent.

(3) The participating health care provider must agree to obtain, at his or her own expense, a physical examination within 60 days before performing service under this partnership agreement. No later than five days before performing services under this agreement the participating health care provider must provide to the MTF a physical examination certification which states the date on which the physical examination was conducted, the name of the doctor who performed the examination, and a statement concerning the physical health of the provider. The certification must contain the following statement: "(Name of participating health care provider) is suffering from no physical disability or medical condition which would restrict or preclude him or her from providing services as a physician (or other type of CHAMPUS authorized-health care provider). (Name of the provider) is sufffering from no contagious diseases to include but not limited to AIDS, tuberculosis, hepatitis, and venereal disease and is not positive for HIV antibodies." Further, the participating provider must agree to undergo personal health examinations and such other medical and dental examinations at any time during the term of this agreement, as the MTF commanding officer nay deem necessary for preventive medicine, quality assurance, and privileging purposes. These examinations may be provided by the MTF and DTF, or if the participating provider so chooses, by private physician or dentist, at no additional cost to the Government.

(4) In the event of illness or incapacity rendering the

participating provider incapable of delivering services, care for patients under this agreement may be transferred to other participating health care providers at the discretion of the commanding officer of the Naval Medical Clinic Annapolis.

(5) The term of this agreement is _____, with the potential option to renew for _____, based upon mutual agreement with the MTF and written approval of the cognizant GEOCOM and the CHAMPUS FI.

(6) The participating health care provider must abide by Navy rules concerning the confidentiality of patient records, as enbodied in the Privacy Act of 1974.

(7) Participating health care providers must abide by Department of the Navy regulations concerning the release of information to the public, including advance approval from the Department of the Navy before publication of technical papers in professional and scientific journals.

(8) Care rendered persuant to this agreement will not be a part of a study, research grant, or other test without the written consent of the MTF, OCHAMPUS, and the Assistant Secretary of Defense (Health Affairs).

(9) The MTF's liability for actions of its employees (MTF staff and military department practitioners, but excluding participating health care providers) is governed by 10 U.S.C. 1089.

(10) The Government may terminate this agreement upon

documentation of revocation of clinical privileges, failure to abide by the provisions of the agreement, abuse of its provisions, or abuse or fraud committed against any agency of the Government by the provider, or in the event of illness or incapacity leaving the participating health care provider incapable of delivering services.

(11) Permanent revocation of clinical privileges and permanent adverse administrative actions due to professional misconduct against a licensed or certified participating health care provider must be reported to the appropriate professional licensure clearing house or to the licensing authorities of the state of _____, following SECNAVINST 6401.2 In addition, participating health care providers are advised that the Department of Defense participates in the national reporting system established under Part B of the Health Care Quality Improvement Act of 1986, Public Law 99-660. Reports naming individual providers must be submitted to the National Data Bank following this Act.

(12) Termination of this agreement is predicated upon satisfactory written notice to the other party not less than 90 days before the proposed termination date. However, the 90-day notice may be waived by mutual consent of the parties to the agreement, or unilaterally for the convenience of the Government, including its mobilization requirements.

IN WITNESS WHEREOF, each of the parties hereunto has executed this agreement on this _____ day of _____, 19__.

UNITED STATES OF AMERICA

By _____

Title _____

PARTICIPATING HEALTH CARE PROVIDER

Name _____

Address _____

(From NAVMEDCOM Instruction 6320.29)

APPENDIX F

SAMPLE PARTNERSHIP FEE SCHEDULE FORM

I, Dr. _____, will accept _____ percent of the CHAMPUS prevailing rate for mental health services performed at the Naval Medical Clinic Annapolis, MD for the period from _____ through _____. I understand that I will be reimbursed only for those procedures which are authorized CHAMPUS benefits, and those procedures specifically allowed by the medical treatment facility commanding officer. My CHAMPUS authorization number is _____.

_____ _____

(Date) (Provider's Signature)

_____

(Provider's Address)

APPENDIX G

SAMPLE PARTNERSHIP AGREEMENT RENEWAL FORM

IT IS HEREBY AGREED by and between _____ of _____ (address) and the United States of America, as follows:

THAT the agreement entitled "Memorandum of Understanding" and the fee schedule, hereinafter referred to as the agreement, entered into by the above named parties on the _____ day of _____ 19__, is hereby renewed for a period of _____ (month or years) from _____ to _____.

THAT all terms and conditions of the agreement remain unchanged and in effect in the agreement as renewed, save only the fee schedule, which is updated and attached, and the maximum charge is the ____ percentile of the CHAMPUS prevailing rate.

THAT this writing is a written memorandum of an earlier verbal agreement to renew, entered into by the parties thereto, prior to the expiration of the original agreement.

EFFECTIVE this _____ day of _____, 19__.

WITNESS the signatures of the parties or their representative.

FOR THE UNITED STATES	PARTICIPATING HEALTH CARE PROVIDER
By _____	_____
(Commanding Officer's Signature)	(Provider's Signature)

(MTF's Name)	(Provider's Name)
(MTF's Address)	(Provider's Address)

APPENDIX H

PSYCHIATRY (GROUP I)

ICD-9-CM DX CODE	TITLE
290	SENILE/PRESENILE PSYCHOSES
291	ALCOHOLIC PSYCHOSES
292	DRUG PSYCHOSES
293	TRANSIENT ORG MENTAL DIS
294	OTHER ORGANIC PSYCH COND
295	SCHIZOPHRENIC DISORDERS
296	AFFECTIVE PSYCHOSES
297	PARANOID STATES
298	OTH NONORGANIC PSYCHOSES
299	PSYCHOSES OF CHILDHOOD
300	NEUROTIC DISORDERS
301	PERSONALITY DISORDERS
306	PSYCHOPHYSIOLOGIC DIS
310	NONPSYCHOTIC BRAIN SYND
316	PSYCHIC FACTOR WITH OTH DIS

PSYCHIATRY (GROUP II)

ICD-9-CM DX CODE	TITLE
302	SEXUAL DISORDERS
303	ALCOHOL DEPENDENCE SYND
304	DRUG DEPENDENCE
305	NONDEPENDENT DRUG ABUSE
307	SPECIAL SYMPTOM NEC
308	ACUTE REACTION TO STRESS
309	ADJUSTMENT REACTION
311	DEPRESSIVE DISORDER NEC
312	CONDUCT DISTURBANCE NEC
313	EMOTIONAL DIS CHILD/ADOL
314	HYPERKINETIC SYNDROME
315	SPECIFIC DEVELOP DELAYS

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